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Building a Regional Health Equity Movement

The Grantmaking Model of a Local Health Department

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The Boston Public Health Commission's Center for Health Equity and Social Justice provides grant funding, training, and technical assistance to 15 organizations and coalitions across New England to develop, implement, and evaluate community-based policy and systems change strategies that address social determinants of health and reduce racial and ethnic health inequities. This article describes Boston Public Health Commission's health equity framework, theory of change regarding the elimination of racial and ethnic health inequities, and current grantmaking model. To conclude, the authors evaluate the grant model and offer lessons learned from providing multiyear regional grants to promote health equity. **Key words:** *REACH*, *health equity*, *racism*, *social determinants of health*

THE Center for Health Equity and Social Justice (further on referred to as the Center) at the Boston Public Health Commission (BPHC) is committed to advancing health equity strategies in Boston and across New England. The BPHC has a unique opportunity as a local health department and designated Racial and Ethnic Approaches to Community Health (REACH) US Center of

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Excellence in the Elimination of Disparities to leverage both city and federal resources to support a regional grantmaking model to promote health equity. This approach is imbedded in the Center's health equity framework, which includes 1) an understanding of how racism shapes the social determinants of health and 2) strategies that reflect the social ecological model. The Center currently provides grants to 15 community-based organizations, institutions, and community coalitions in Massachusetts, Connecticut, and New Hampshire, to implement community-driven policy and systems change strategies that address a variety of social determinants of health. It is through this grantmaking model that the Center hopes to support community-led, comprehensive, and sustainable changes to eliminate racial and ethnic health inequities in communities across New England.

BACKGROUND

The 6 New England states (Maine, Massachusetts, Vermont, Connecticut, Rhode Island, and New Hampshire) are home to an estimated 14.4 million people, 70% of whom live in Massachusetts or Connecticut.[1] Connecticut and New Hampshire have seen significant population growth and increasing racial diversity in recent decades. The largest cities in these states, Boston, Hartford, Bridgeport, and New Haven, have populations with more than 50% identifying as people of color.[2-4]

Despite their geographic and demographic differences, racial and ethnic disparities in social and economic conditions exist in similar proportions across the region. Differences in poverty rates, income, educational attainment, and employment can be seen between racial groups in the region.[3-6] Examples of black, white, and Hispanic socioeconomic indicators in Boston, Massachusetts, and Connecticut are illustrated in Table 1.

In addition to social and economic disparities, health outcomes across the region also differ by race, with black and Hispanic residents often experiencing poorer health than their white counterparts. These data consistently show differences between racial groups across a number of health indicators in Connecticut, Massachusetts, and Boston, as shown in Table 2. For many diseases and causes of mortality, black residents have at least 1.5 to 2 times the risk compared with white residents.[4,7,8] Hispanic residents in the region have lower risk of mortality overall and a lower risk of death from cancer and cardiovascular conditions, such as heart disease and stroke. However, Hispanics have much

Table 1. Socioeconomic Disparities by Race in New England[a,b]

	Boston			Massachusetts			Connecticut		
	White	Black	Hispanic	White	Black	Hispanic	White	Black	Hispanic
Poverty	14	25	30	8	20.5	28.7	6.3	18.1	23.1
		(1.8)	(2.1)		(2.6)	(3.6)		(2.9)	(3.7)
Education level									
BA or higher	52.6	17	15.5	38.7	21.7	15.7	36.7	18	14.5
		(0.3)	(0.3)		(0.6)	(0.4)		(0.5)	(0.4)
High school/	32.5	32.5	68	37.7	49.5	65.3	38.5	53.2	64.1
GED or lower		(1.8)	(1.2)		(1.3)	(1.7)		(1.4)	(1.7)
Unemployment	5	11.2	10.3	4.7	12.8	10.4	5.2	12.2	10.4
		(2.2)	(2.1)		(2.5)	(2.2)		(2.3)	(2.0)

[a]From US Census Bureau.[3]
[b]Values represent rate, % (relative risk).

Table 2. Racial Health Disparities in New England[a,b]

	Boston			Massachusetts			Connecticut		
	White	Black	Hispanic	White	Black	Hispanic	White	Black	Hispanic
All-Cause mortality	727.9	1010.3 (1.4)	478.9 (0.7)	713.7	843.2 (1.2)	463.8 (0.6)	707.4	882.2 (1.2)	558.4 (0.8)
Infant mortality (deaths per 1000 pop.)	3.4	11.3 (3.3)	6.8 (2.0)	3.9	10.2 (2.6)	7.5 (1.9)	3.9	13 (3.3)	6.5 (1.7)
Low birth weight (percent of total births)	8.4%	12.7 (1.5)	8.4% (1.0)	7.4	11.1 (1.5)	8% (1.1)	6.70%	12.9% (1.9)	8.5% (1.3)
Heart disease mortality	148.8	182.1 (1.2)	93.4 (0.6)	170.1	182.6 (1.1)	91.3 (0.5)	198.6	233.8 (1.2)	139.6 (0.7)
Stroke mortality	37.8	56 (1.5)	22.4 (0.6)	36	45.9 (1.3)	27 (0.8)	42.2	57 (1.4)	33.5 (0.8)
Cancer mortality	183.4	276.3 (1.5)	107.7 (0.6)	186.4	206.8 (1.1)	96.3 (0.5)	180.6	206.7 (1.1)	114 (0.6)
Diabetes prevalence	4%	10% (2.5)	6% (1.5)	5.9%	8% (1.4)	8.1% (1.4)	5.30%	12.8% (2.4)	11.4% (2.2)
Diabetes hospitalization	429.4	1093.3 (2.6)	645.9 (1.5)	314.7	952 (3.1)	486.9 (1.5)	94.5	359.4 (3.8)	213.4 (2.3)
Asthma hospitalization (age-adjusted)	139.4	481.8 (3.5)	337 (2.4)	110	329.3 (3.0)	292.4 (2.7)	84.5	316.7 (3.7)	331 (3.9)
Asthma ED visits (age-adjusted)	358.4	2074 (5.8)	1214.7 (3.4)	434.4	1469.2 (3.4)	1250.7 (2.9)	32.7[c]	151.2[c] (4.6)	169.7[c] (5.2)

Abbreviation: ED, emergency department.

[a] From Stratton et al,[4] New Hampshire Office of Minority Health,[6] and Boston Public Health Commission Research and Evaluation Office.[7]

Data in this table are from the most current reports available from the Boston Public Health Commission (2009), the Massachusetts Department of Public Health, and the Connecticut Department of Public Health (2009), however the dates of data vary depending on the source and frequency of collection. Follow the citation for specific data sources and dates.

[b] Values represent rate, % (relative risk).

All rates are per 100 000 population unless otherwise noted.

[c]These rates are age-specific for children 0 to 17 years old.

higher rates of diabetes prevalence, diabetes hospitalization, asthma hospitalization, and asthma emergency department visits than their white counterparts in Boston, Massachusetts, and Connecticut.[4,7,8]

It is no coincidence that black and Hispanic residents in the region experience poorer socioeconomic and health outcomes than white residents, but it is not inevitable. Although biology and behavior impact individuals' health, they do not account for the persistent inequities between white and nonwhite communities.[9] Racial and ethnic health inequities are rooted in the unequal and unjust distribution of social and economic resources and opportunities across communities.[10] Place is a strong predictor of health outcomes because social, economic, and environmental resources, opportunities, and exposures are unevenly distributed by location, often following racial and socioeconomic lines.

Through pervasive US social and economic policies, structural racism has systematically denied communities of color resources and opportunities that promote health and socioeconomic stability. US history provides examples of race-based policies that have shaped the social, geographic, and economic landscape. Examples of race-based policies have included housing discrimination, unfair urban renewal policies, disinvestment in public transportation in communities of color, discriminatory zoning practices, and racial profiling and incarceration policies. Between 1934 and 1968, the Federal Housing Administration practiced "redlining," which drew red lines on maps delineating white neighborhoods from communities of color and used those distinctions as the basis by which to deny or limit mortgage financing.[11] Redlining successfully segregated residential neighborhoods, which impacted public schools by concentrating black students in predominantly black schools.[11] Although public schools were constitutionally desegregated in 1954 through the decision of Brown versus the Board of Education, many schools remain segregated as a result of other social policies that shape where people live and how public school districts are determined and funded.[12]

Residential segregation and other social and economic policies, both historical and contemporary, influence factors such as income, education, employment, housing, food access, health care access, and environmental exposures. This concentration of poor socioeconomic and health outcomes in communities of color creates unjust disparities among racial and ethnic populations. Often referred to as the "social determinants of health," these factors and other features of the physical, built, and social environments have direct or indirect impacts on population health.

When mapped, the relationship between race, social and economic conditions, and health becomes clearly evident. For example, 92% of Boston's black residents live in just 7 of the city's 17 neighborhoods.[7] These neighborhoods also have the city's highest rates of poverty, foreclosure petitions, incidence of lead poisoning in children younger than 5, and heart disease and asthma hospitalizations (see maps in Figures 1-5).

A SHIFT IN PARADIGM AND PRACTICE

Health disparities that reflect the unjust distribution of resources, power, and opportunities are called health inequities. These inequities are rooted in racism, determined by social conditions, and require new public health approaches to achieve health equity.[13,14] Conventional approaches to eliminating health disparities include targeted public health interventions like increasing screenings, health education, and disease management resources in communities of color. The objective of many traditional approaches is to increase access to and the cultural competency of programs and services aimed at changing health behaviors and providing health care services. These interventions remain essential to public health practice, however, given the persistent health inequities between communities of color and white communities there is little data to indicate that these traditional approaches

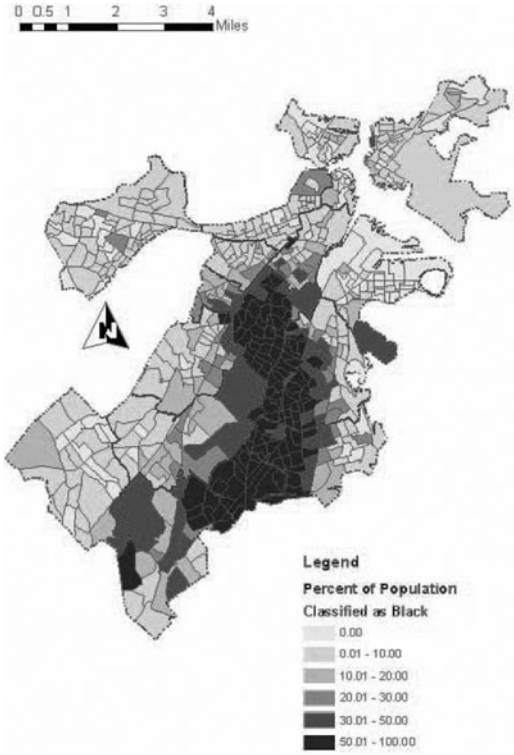

Figure 1. Residences of black population in Boston. From the annual Health of Boston Report: Boston Public Health Commission. 2000 US Census.

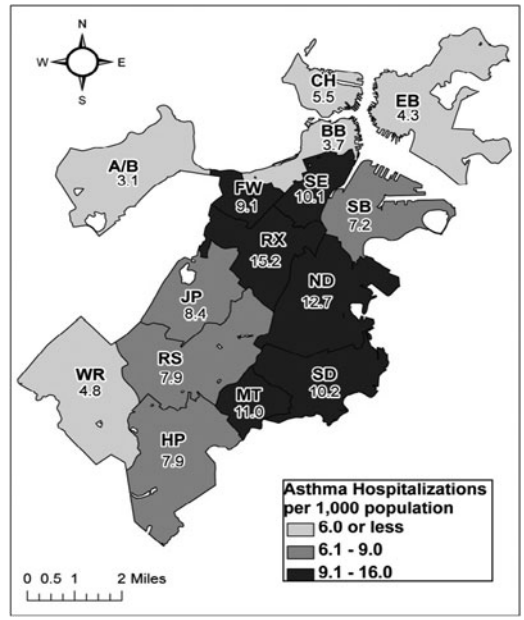

Figure 2. Asthma hospitalizations of children younger than 5 years by neighborhood, 2005, 2006, and 2007 combined. From the annual Health of Boston Report: Boston Public Health Commission.

significantly close the gap at the community and population levels. Given this lack of evidence and a growing body of research demonstrating the strong connections between social determinants of health and health outcomes, new approaches to address health inequities are emerging.[15-20]

These new approaches focus on changing social and economic conditions for communities of color through community engagement and policy and systems change work.[21,22] In addition, some public health organizations and local health departments have begun to participate in cross-sector collaborations to address social policies and systems that are not traditionally under the purview of public health, such as housing, transportation, community economic development, and parks and recreation.[21-24] These new approaches aim to address the root causes of inequities to bring about positive, sustainable change for communities of color.

The BPHC's approaches to reduce racial and ethnic health inequities have evolved over the past 10 years to adopt a framework that promotes policy and community-based strategies to address the social determinants of health and achieve health equity.

History

Between 1999 and 2007, the BPHC was a part of REACH 2010, a cornerstone of the Center for Disease Control and Prevention's early initiatives to address racial and ethnic health disparities. The Boston REACH 2010 Coalition guided the Commission's community-driven efforts to understand and confront social determinants of health believed to contribute to excess breast and cervical cancer deaths among black women. REACH-funded case managers and health educators helped women identify and address social conditions that influenced their health and

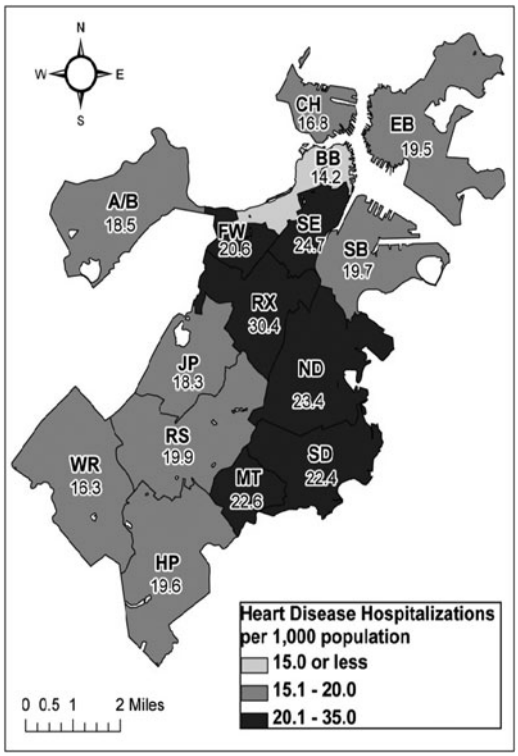

Figure 3. Heart disease hospitalizations by neighborhood, 2005, 2006, and 2007 combined. From the annual Health of Boston Report: Boston Public Health Commission.

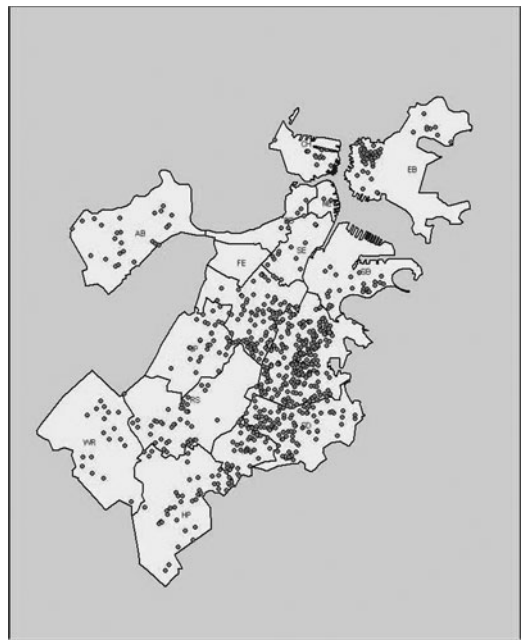

Figure 4. Residences of Boston children with elevated blood levels. From the annual Health of Boston Report: Boston Public Health Commission.

provided referrals to address patient-identified social concerns (e.g., transportation, housing, language barriers, safety, employment, education, health care access). Analysis of the data collected at 7 area health centers showed that case management was effective in increasing the number of black women who received baseline breast and cervical cancer screening, but was not consistently able to ensure that women serially engaged routine screenings.[25] Issues related to housing, childcare, and health insurance coverage, while temporarily mitigated for some individuals engaged in case management, reflected larger systems issues and required a more comprehensive approach. The project suggested that closing the gap on a population level would require further investment in interventions in the outer rungs of the social ecological model (Figure 6), that is, creating policy and systems-level change across the social determinants of health.

In 2005, the Mayor's Health Disparities Task Force, a group of leaders from business, community coalitions, health centers, academic institutions, hospitals, and insurance companies, issued a set of detailed recommendations, making Boston among the first cities in the United States to establish a citywide blueprint for addressing racial and ethnic inequities in health. The Task Force identified social factors influencing health such as the environment, housing, poverty, stress, racism, neighborhood infrastructure, and residential segregation. Its recommendations provided opportunities for action for housing agencies, public safety officials, educators, business leaders, health care institutions, elected officials, health insurers, and others.

The Boston Disparities Project was formed at the BPHC to help implement the blueprint and between 2005 and 2007, awarded 54 grants to hospitals, community agencies, and

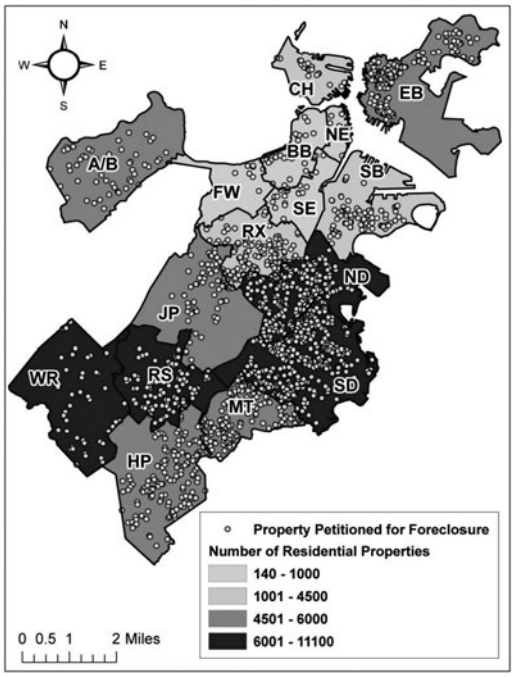

Figure 5. Foreclosure petitions and number of residential properties by neighborhood, 2007. From the annual Health of Boston Report: Boston Public Health Commission.

other groups to support education, training, advocacy, planning, and services focused on workforce diversity, food access, patient navigation, and violence prevention.[26] Grantees reported a marked increase in their understanding of the social determinants of health and the need for comprehensive strategies; however, the 12-month grant cycle did not fully support their advancement of sustainable policy changes.

The combined efforts of the REACH 2010 Coalition and Disparities Project (which later became the Office of Health Equity) were recognized and funded in 2007 as a REACH US Center of Excellence in the Elimination of Disparities by the Centers for Disease Control and Prevention. As a Center of Excellence in the Elimination of Disparities, the BPHC had a unique opportunity to build on the lessons from the Office of Health Equity and the REACH Coalition to develop a unified health equity agenda. As a joint office, the work of REACH and the Office of Health Equity became formally known as the Center for Health Equity and Social Justice in 2008.

The Center works to support the BPHC's vision to eliminate racial and ethnic health disparities and build health equity through community, policy, and systems change. The Commission's framework focuses on the relationship between social factors and health outcomes, with an analysis of the unique and independent role that structural racism plays on these social factors. In service of the Commission's priority to work collaboratively with communities to eliminate health inequity, the Center provides funding, training, and technical assistance to communities and organizations in Boston and Southern New England. Between 2008 and 2009, the Center has leveraged federal and local monies to fund 15 grantees for 3-year cycles. The 3-year grant cycle reflects the lessons learned from the Disparities Project and the REACH Coalition: long-term systems, policy, and environmental change require an investment of time. This understanding, coupled with a shift in broader public health discourse, highlighted that the social conditions that result in poorer health outcomes for communities of color are complex and require comprehensive community-driven strategies, not simply single-focus interventions.[27] The current granting model is designed to support community and institution-level analysis of health data and related social determinants, the development of a strategic plan, and outcomes measured by policy, systems, or environmental change that improve the social conditions as they relate to the identified inequities in health. The social ecological model and the community-based participatory nature of this approach are simple in theory, yet challenging to implement.[27]

DEVELOPING A HEALTH EQUITY FRAMEWORK

The BPHC aims to achieve racial and ethnic health equity through community, policy, and systems change. The Center has developed

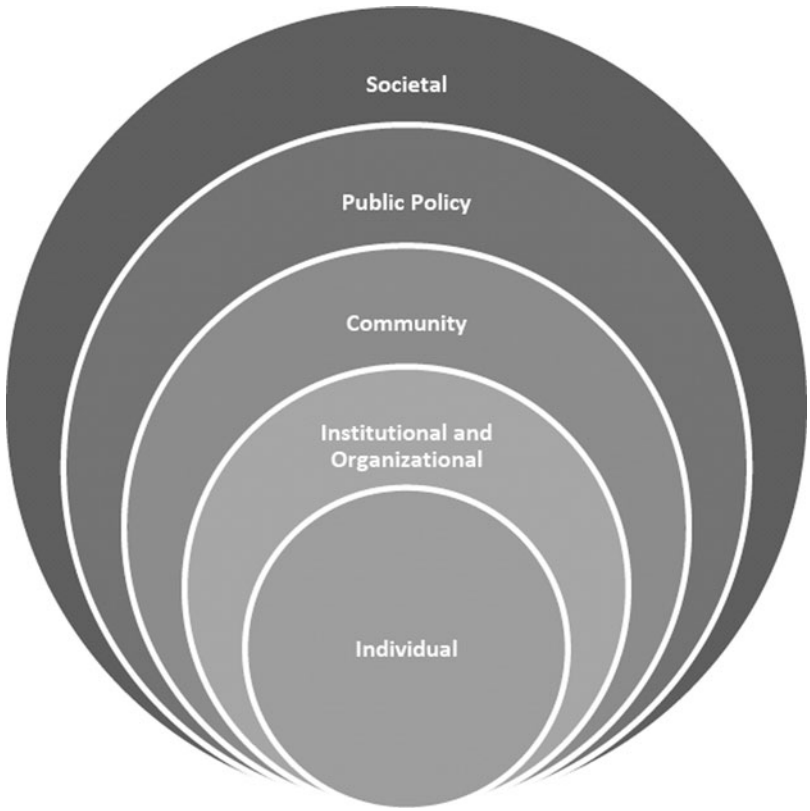

Figure 6. The social ecological model. From Boston Public Health Commission.

its health equity definitions and strategies through an analysis of the intersection of racism, social justice, and community engagement. The following operating principles help to guide this work: (*a*) commitment to racial justice; (*b*) commitment to social change; (*c*) accountability to the community; (*d*) integrity in our internal and external processes; and (*e*) collaboration and shared learning.

The National Institutes of Health defines *health disparities* as "the differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exist among specific population groups in the United States."[28] For the BPHC, the term *health disparities* implies differences in health between individuals or population groups but does not offer an explicit analysis as to why those differences exist.

Health inequities differ from health disparities in that they refer to differences in health outcomes that are not only unnecessary and avoidable but they are also unfair or unjust.[27] Health equity, as widely defined in public health, is the opportunity for everyone to "attain their full health potential" and when "no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance."[29] The Center uses this understanding of health equity as a key driving factor for all programmatic and policy strategies.

The BPHC utilizes a framework that highlights racism and discrimination as root causes of inequities in health and that recognizes comprehensive, multilevel racial justice strategies as fundamental to achieving racial and health equity. The Center's work is rooted in the understanding that health status

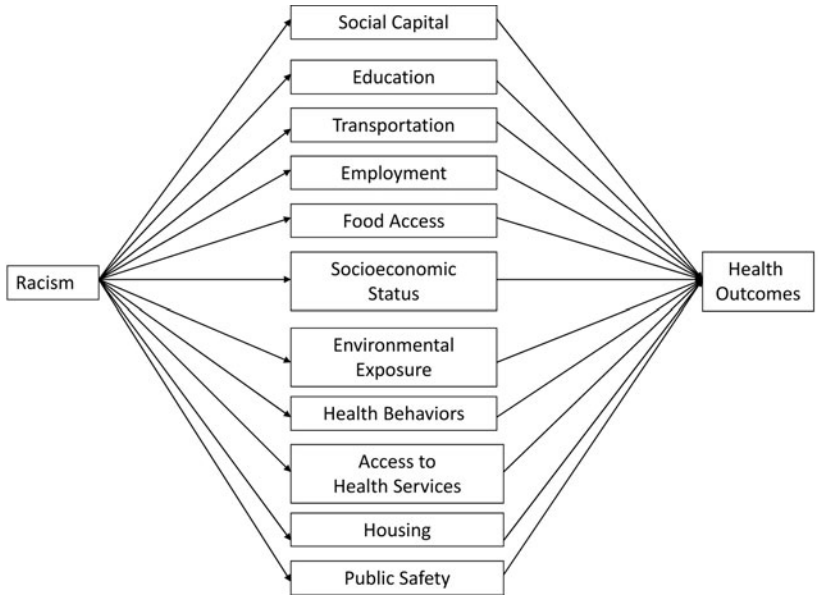

Figure 7. Boston Public Health Commission's health equity framework.

is influenced by environmental conditions, social relationships, and institutional structures and that individual choices and behavior are largely shaped by the resources available in the places where people live and work. The Center's health equity framework (Figure 7) suggests that racism has an independent influence on all the social determinants of health and that racism in and of itself has a harmful impact on health.

A commitment to antiracism

Significant discourse about racism in the United States and globally has led the Commission to an understanding of racism on multiple levels.[13,30,31] The Commission's framework is based largely on Dr Camara P. Jones' analysis of the levels of racism: internalized, personally-mediated, and institutional.[30] A fourth level of racism, structural racism, refers to a system of social structures that produces cumulative and well-maintained inequities.[31] Understanding structural racism requires an analysis of how historical policies, practices, programs, and institutions "operate. . .interactively to distribute material and symbolic advantages and disadvantages along racial lines."[31] Improving the social conditions necessary for promoting optimal health cannot happen without understanding and undoing racism.

FROM THEORY TO PRACTICE – GRANTMAKING FOR HEALTH EQUITY

The guiding principles, definitions of health equity and disparity, tools, and frameworks outlined earlier collectively represent the orientation of the Center. In addition to these definitions, tools, and frameworks, the Center utilizes the social ecological model to translate its work from theory to practice (Figure 6). The social ecological model helps to define, categorize, and organize the Center's strategies in terms of its spheres of influence and impact across the individual, institutional, community, public policy, and societal levels. The Center's granting model, which is described in detail later, funds community-based organizations and coalitions, as well as some large institutions in Boston and across New England. This grant making work generally falls within

Table 3. Funding Details

Overview	
Number of grantees as of May 2010	15
Amount of funding awarded to grantee communities[a]	$1 109 925.00
Average 12 mo grant award	$24 665.00
Number of states with grantee communities	3 (Massachusetts, New Hampshire, and Connecticut)

[a] Does not include $90 000 of supplemental funds awarded to grantees to support strategic planning in the first year of the award.

two spheres of the model: the community and the institutional and organizational levels.

Between 2008 and 2012, the Center will provide funding to more than 15 organizations and community coalitions in Boston and throughout New England, totaling more than $1.1 million. The Center's grant funding is intended to support the development, implementation, and evaluation of community-based strategies that address the social determinants of health and reduce racial and ethnic health inequities. Funded organizations include single agencies and institutions as well as multiagency, cross-sector community coalitions, each receiving between $25 000 and $30 000 annually for 3 years (Table 3). In addition to providing the organizations with funding, the Center provides education, training, and technical assistance to grantees. This granting model is designed to provide coalitions and organizations with the tools and resources necessary to work with the community to analyze health inequities in their communities and develop policy and systems-level approaches to reducing the inequities. To foster shared learning and support, all grantees participate in the New England Partnership for Health Equity, a regional learning collaborative maintained through regional meetings, conference calls, and biannual conferences. Although the specific activities of each grantee vary, the elements of the Center's grant model outlined later reflect the BPHC's health equity framework and theory of change.

Selection of grantees

Grantees were selected through a competitive Request for Applications process that assessed their history of working within communities of color, their commitment to the elimination of health inequities, their capacity to do policy and systems-level change work, and their capacity to lead in a multiyear comprehensive plan of action. Eligible organizations included community-based organizations, educational institutions, community health centers, hospitals, neighborhood associations, faith-based organizations, state, local, or county public health departments, and other nongovernmental agencies in Boston or in 1 of the 6 New England states.

Funding tracks were established to reflect some of the priorities of the BPHC. "Food access" funding supports efforts that address factors in the food environment that are the major determinants of obesity, chronic disease, and food insecurity among low-income residents of color. "Workforce diversity" funding supports efforts to increase opportunities for youth of color to enter health careers. Grantees in the third funding track use community-based participatory approaches to collect data and identify the social factors related to the racial inequities seen in their respective communities (Table 4).

Training and technical assistance

In an effort to support grantees through a paradigm shift for developing new

Table 4. Grantee Organizations, Funding Details, Location, and Priority Areas

Grantee Name	Location	Type of Organization	Dates of Award Cycle	SDoH Area of Focus
American Red Cross of Massachusetts Bay	Cambridge, Massachusetts	Nonprofit	October 2008 to September 2011	Education
Bowdoin Street Health Center	Boston, Massachusetts	Health care	October 2008 to September 2011	Food access
Central Connecticut Area Health Education Center	Hartford, Connecticut	Nonprofit	October 2009 to September 2012	TBD through needs and asset assessment process
Edward M. Kennedy Academy for Health Careers	Boston, Massachusetts	Public high school	October 2008 to September 2011	Education
Henry Lee Willis Community Center	Worcester, Massachusetts	Nonprofit	October 2008 to September 2011	Education
Ledge Light Health District	Groton, Connecticut	Local health department	October 2009 to September 2012	TBD through needs and asset assessment process
New Hampshire Minority Health Coalition	Manchester, New Hampshire	Nonprofit	October 2008 to September 2011	Public safety
North Central MA Minority Coalition	Fitchburg, Massachusetts	Nonprofit	October 2008 to September 2011	Education
Partners for a Healthier Community	Springfield, Massachusetts	Nonprofit	October 2008 to September 2011	Food access
Sociedad Latina	Boston, Massachusetts	Nonprofit	October 2008 to September 2011	Built environment, Food access
Southern Connecticut State University	New Haven, Connecticut	Public university	October 2009 to September 2012	TBD through needs and asset assessment process
Southern Jamaica Plain Health Center	Boston, Massachusetts	Health care	October 2008 to September 2011	Education, Employment
The Food Project	Boston, Massachusetts	Nonprofit	October 2008 to September 2011	Food access
The Mattapan Food and Fitness Coalition	Boston, Massachusetts	Nonprofit	October 2008 to September 2011	Built environment, Food access
Youth and Family Enrichment	Boston, Massachusetts	Nonprofit	October 2008 to September 2011	Education

Abbreviations: SDoH, Social determinants of health; TBD, to be determined.

approaches to eliminating health inequity, the Center has matched the value of grant funding with a selection of training and hours of technical assistance to support grantee efforts over the 3 years. (Grantee process, timeline, and technical assistance are illustrated in Figure 8.) During year 1, all grantees receive training from BPHC staff on the Center's health equity framework, which includes an analysis of the effects of racism and the social determinants of health on health inequities. This training also demonstrates how data are collected and analyzed to illustrate racial and ethnic health inequities and related social determinants. In the first year, grantee teams are required to participate in an Undoing Racism and Community Organizing workshop facilitated by the People's Institute for Survival and Beyond. The Undoing Racism workshop provides a historical analysis of racism and engages participants in discussions about community organizing, leadership development, internalized oppression and privilege, and strategies for undoing racism.[33] The workshop provides grantees with a deeper understanding of the historical and present-day social conditions that shape racial and ethnic health inequities. Additional trainings are offered to grantee teams at each of the biannual grantee summits. Topics have included coalition building, community organizing, community needs and asset assessments, policy advocacy, logical models and evaluation, and framing and communicating racial equity.

Throughout the grant cycle, grantees receive technical assistance from the Center and from a team of expert advisors who offer specific expertise on the basis of the unique needs of grantees as well as the broader learning community. Grantees receive regular calls from Center staff to discuss progress and address challenges and participate in regular conference calls with other grantees to promote shared learning. Center staff also communicate with grantees through bimonthly e-mail updates, funding opportunities, articles, reports, and other resources. Grantees also have opportunities to engage with expert faculty, consultants on contract with the Center, who offer coaching and support around coalition building, strategic planning, and promotion of antiracist social change. Also, if funding allows, grantees can apply for supplemental funds to work with a consultant to develop a strategic plan, logic model, and/or evaluation plan for their health equity work. All training and technical assistance is designed to provide grantees with practical tools and skill-building community organizing, developing logic models, data collection, and policy development.

Developing unique health equity agendas and strategic plans

A significant process and outcome in the first year of the grant is a community-led needs and asset assessment. The assessment process is different for each grantee; institutions and agencies conduct an assessment of the needs and assets of their clients and consumers, while community coalitions assess the needs and assets of their target geographic communities. The goal of the assessment process is to identify the unique needs and assets of the community that will drive the policy, system, or environmental change strategies to be implemented in years 2 and 3 of the grant.

Following the assessment process, all grantees develop strategic plans to guide their strategies. Although the formats of the strategic plans vary (e.g., logic models, written reports, presentations), all grantees' strategic plans include their inputs, activities, outputs, objectives, and goals for their health equity work.

In addition to programmatic and capacity-building activities, all grantees must include policy and systems change objectives in their strategic plans. The policy and systems change goals of the institutional grantees most often reflect organizational policy and practice changes, such as improving programmatic service delivery and including more consumer voice and feedback in program planning. Community coalitions' strategic plans often outline community organizing strategies pertaining to advocating for change

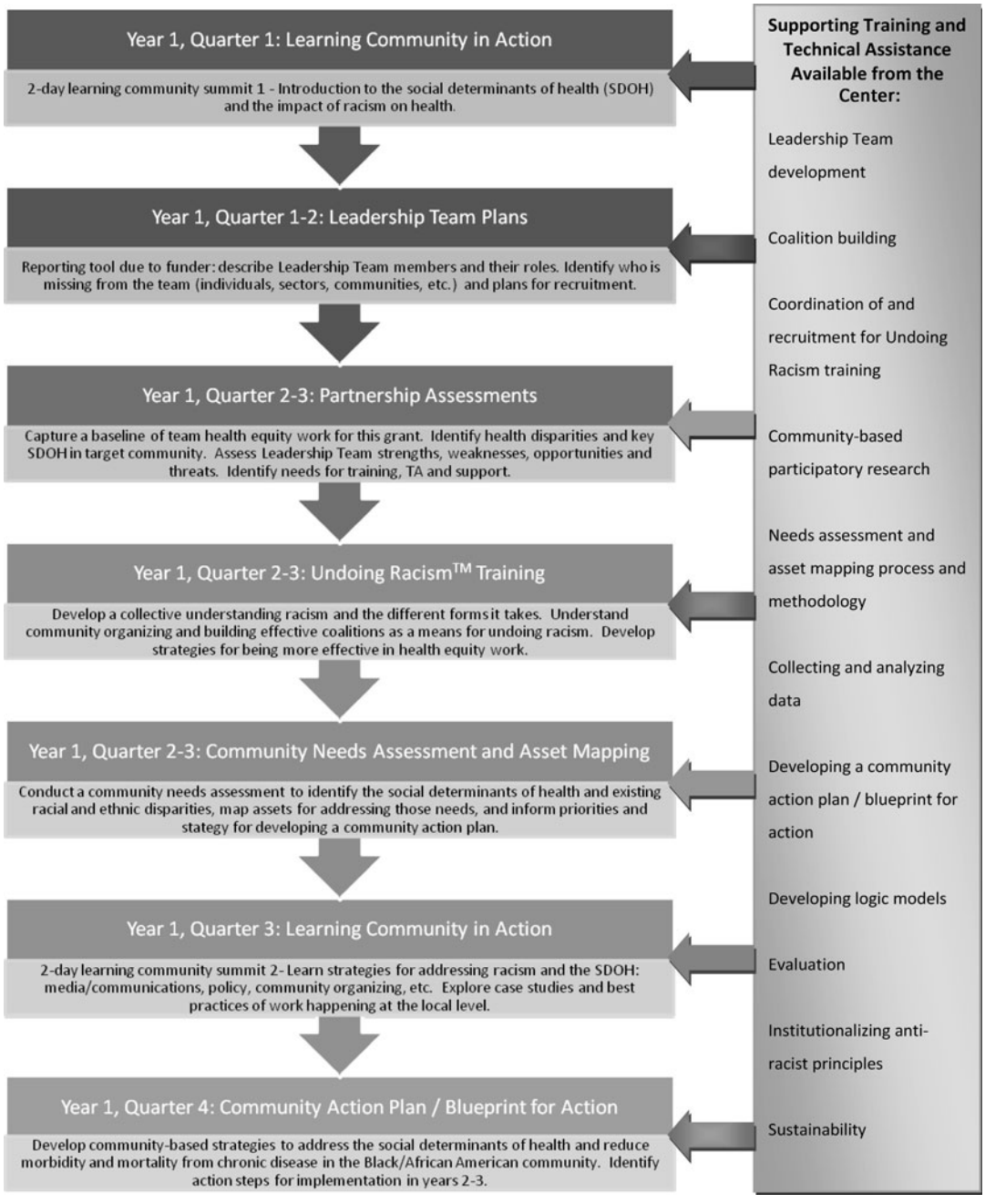

Figure 8. Grantmaking process and timeline. From Boston Public Health Commission. (*Continues*)

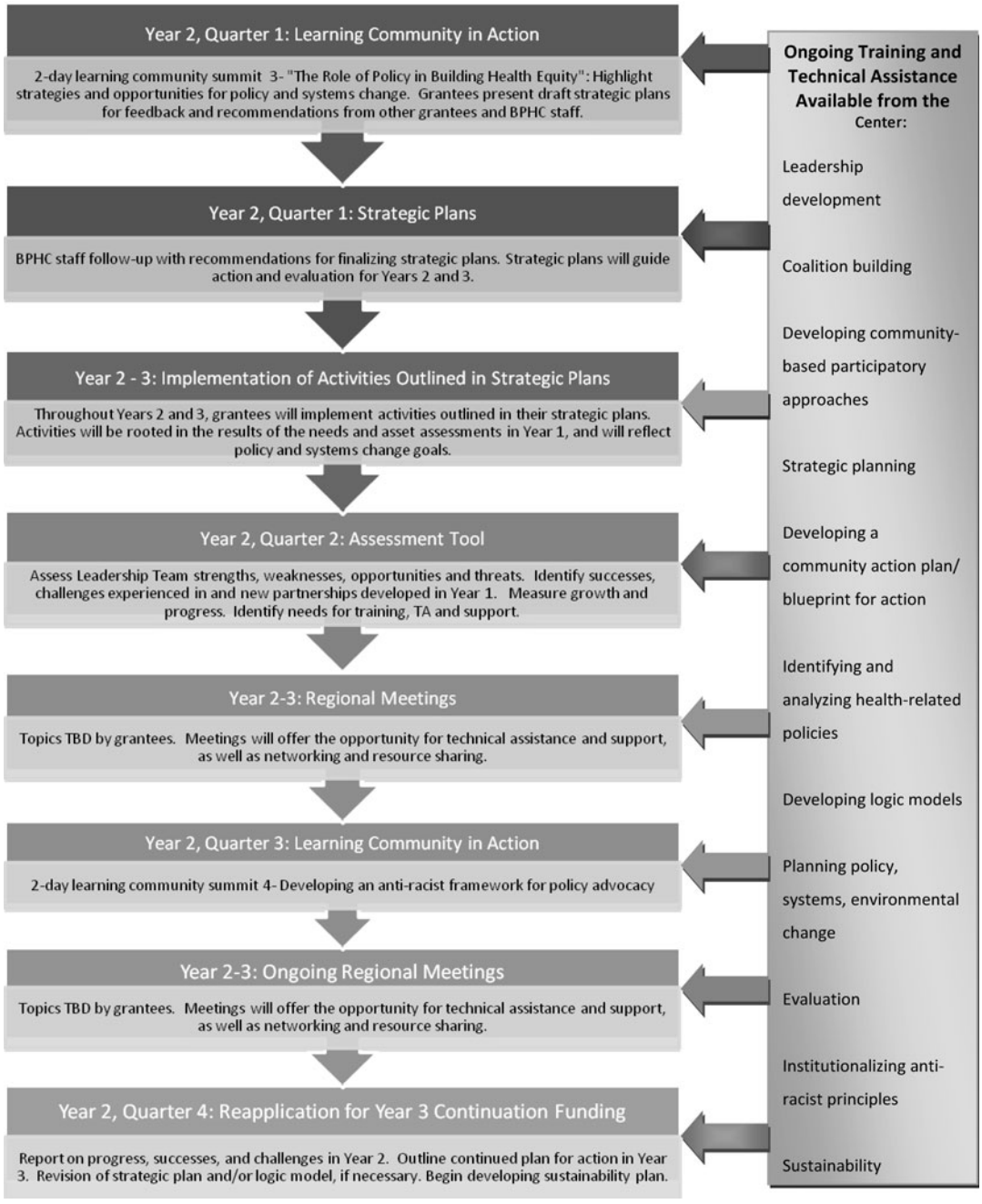

Figure 8. (*Continued*) Grantmaking process and timeline. From Boston Public Health Commission.

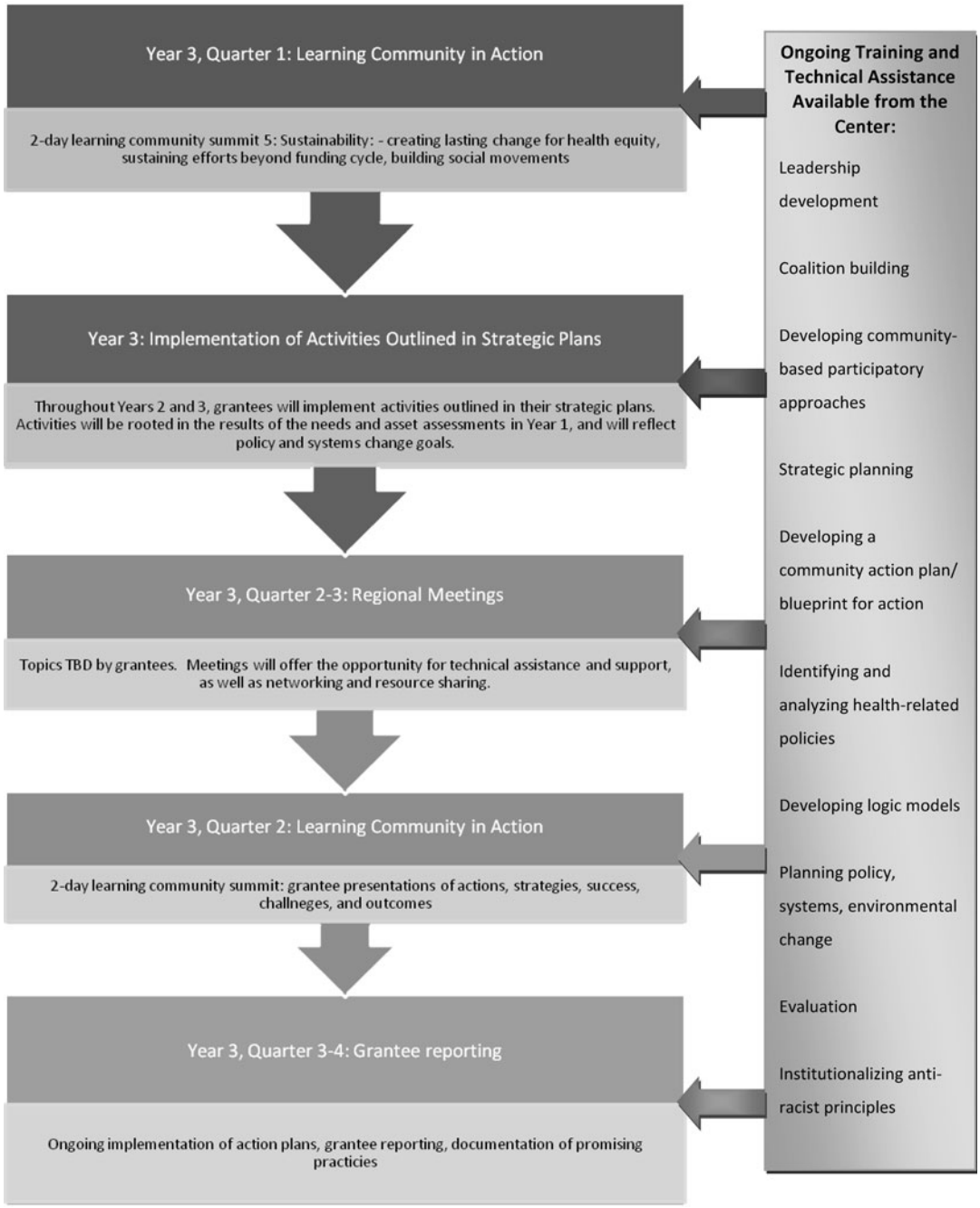

Figure 8. (*Continued*) Grantmaking process and timeline. From Boston Public Health Commission.

in 1 or 2 of the social determinants related to the inequity in health outcomes they previously assessed.

Implementing local action plans

While year 1 of the grants from the Center focuses on assessment and planning, years 2 and 3 of the grant support the implementation and evaluation of the strategies developed in year 1. The strategies developed by the grantees reflect the unique needs and assets of the target populations so the implementation phase is different for each grantee. This model of assessment, planning, and implementation in 3 years requires of grantees a demonstrated understanding of the unique needs and assets of their community; a clear policy and/or systems change agenda that is connected to health inequities in the community; an established cross-sector leadership team to guide the work; and a proven ability to engage community residents.

Despite their varying strategic plans and actions, the Center collects standard qualitative and quantitative data from each grantee to evaluate the success of the grant model. The evaluation of the grantees is 3-fold; the Center measures the capacity of the grantees, the grantees' levels of influence with regard to the social ecological model, and grantees' progress in achieving their stated objectives. A more detailed description of the Center's evaluation of the grantees can be found later. In addition to evaluating grantees' progress, the Center also provides technical assistance and support to grantees to support their own evaluation efforts.

The challenges and successes of grantees' implementation of local action plans reflect a few significant themes. Critical to the success or challenges of implementing an action plan has been the capacity of the grantee organization to analyze and lead a comprehensive policy or systems change strategy. This is new work for many organizations, and it requires time, leadership, and engaged community partners. These grants require organizations and coalitions, which previously (and concurrently) engaged in providing services to address health disparities, to talk about racism, address issues of power, expand their stakeholder base, and think upstream with a social justice lens. Community engagement is essential to the process; however, challenges and changes in leadership, the sharing and shifting of power, and the time that it takes to shift ideology and practice have posed challenges for some grantees. Success has been seen when grantees have used a health equity frame to leverage other resources and partners in support of their action plans.

The New England partnership for health equity—An interstate learning community

A key component of the Center's grant model is the coordination of the New England Partnership for Health Equity (the Partnership), a learning community for grantees. The Partnership provides grantees with opportunities for shared learning and networking with regional colleagues engaged in health equity work. The Partnership convenes each fall and spring at the New England Health Equity Summit. Built into each summit agenda are sessions devoted exclusively for cross-grantee sharing and networking. In addition to the summits, the Center plans to launch a Web site in mid-2010 that will include tools for virtual dialogue and sharing. The interstate learning collaborative is also supported through conference calls and regional meetings.

EVALUATION OF THE GRANTMAKING MODEL

The Center uses several methods to evaluate the granting model. The evaluation of the grant model has 3 fundamental goals: to measure the growth of the grantees' capacity, to assess the grantees' levels of influence over time, and to track grantees' progress in achieving their own unique objectives for their health equity work. Qualitative measures

Table 5. Select Evaluation Measures From CHESJ Grantees in Years 1 to 2[a]

Capacity building	
Number of new Leadership Team members engaged since receiving the grant	48
Percentage of grantees reporting new efforts underway in their agency/leadership team since receiving this grant to address the SDoH and build health equity	100%
Number of grantees reporting that implementation of their strategic plan is under way	8
Number of grantees reporting securing additional funding to support health equity efforts	6
Number of grantees who report participating in other antiracism activities since participation in the Undoing Racism Workshop	7

Abbreviations: CHESJ, Center for Health Equity and Social Justice; SDoH, Social determinants of health.
[a]Note that findings include only 12 grantees funded in October 2008. The 3 grantees excluded from this analysis were funded in October 2009, so only baseline data existed at the time of this report.

capture the capacity of the grantees over time and the effect of the training and technical assistance model on grantees (Table 5).

The 3-year grant cycle is divided into 4 key phases with benchmarks at each phase to capture how the grantee is advancing change. The benchmarks reflect the Center's theory of change related to the development of sustainable health equity work. The goal is for all grantees to achieve all of the phase 4 benchmarks by the end of the grant. Second, the Center measures grantees' levels of influence with the rungs of the social ecological model. Grantee efforts in place at the beginning of the grant are measured against those initiated later in the grant cycle, with the hope that there will be movement toward the outer rungs of the social ecological model (ie, policy, environmental, and systems change). Finally, the grantees' progress toward meeting their own reported objectives is tracked. As described earlier, all grantees are required to submit strategic plans at the end of year 1 of the grant, outlining their goals, objectives, activities, inputs, and outputs for years 2 and 3. The objectives stated in the strategic plans must be SMART (specific, measurable, attainable, relevant, and time-oriented). At several points throughout years 2 and 3 of the grant, the grantees are required to report their progress on their objectives so progress can be measured over time.

To evaluate the success of the grant model, standard qualitative and quantitative data are collected from each grantee at several points throughout the grant cycle. Grantees' initial grant applications and annual reapplications for funding are used as data sources. The strategic plans and logic models submitted at the end of year 1 serve as both an end of year report and a baseline for years 2 and 3 of the grant. Grantees also complete annual Partnership Assessment Tools, which are surveys that capture both qualitative and quantitative information about the grantees' capacity, activities, progress, successes, and challenges. Finally, information gathered through one-on-one calls, e-mails, and meetings with grantees is also used in evaluating the Center's granting model. A limitation of the model is the limited resources for grantees to develop an expansive evaluation of their efforts and the impact on policy, systems, and environmental change. Moreover, there is no longitudinal data collection or evaluation to support the correlation of their social change strategies with marked improvements in the health of the community or in closing the racial gap in health outcomes.

DISCUSSION

In the initial 18 months of the first 3-year grant cycle, most of the available evaluation

Table 6. Examples of Grantee-Led Policy and Systems Change

Policy and systems change	
Changing zoning policy	In support of work on tobacco-control, Sociedad Latina supported a campaign to change the enforcement of storefront advertising zoning code. The amendment, passed successfully by the City Council in July 2009, was the result of multiple years worth of work conducting citywide evaluations, presenting results to the Council and Inspectional Service Department and working with Councilor Mike Ross. Sociedad Latina's Health Educators supported this work by extending the focus beyond simply tobacco advertising to also draw attention to the high incidence of junk food and sugar-sweetened beverage advertising. By using the results of the evaluations, the Youth Leaders drew connections between higher rates of junk food advertising and high incidences of diabetes and obesity, and noted that neighborhoods with higher rates also had larger populations of low income and minority residents.
Expanding AP curricula	The Edward M. Kennedy Academy for Health Careers has been able to grow their calculus program and, as a result, their Advanced Placement program. In 2009 they offered AP Calculus for the first time. The school has submitted a proposal to Boston Public Schools to expand their AP course offerings for next year outside of the 3 courses they currently offer (AP Calculus, AP Biology, and AP English).
New data collection regulations	The New Hampshire Minority Health Coalition successfully advocated for new regulations in the state of New Hampshire that require the collection of standardized race, ethnicity, and language data within 2 key public health datasets: Uniform Hospital Discharge Data and All Payer Claims Data. The regulation will allow public health advocates and public officials to analyze data to better understand and report health inequities. The regulation also works to improve the quality of care for all of the state's patient populations.

Abbreviation: AP, Advanced Placement.

results reflect changes in organizational capacity, and not specific progress toward policy, systems, or environmental objectives, as these outcomes take longer to initiate and measure. By the end of year 2, there will be more data collected on the progress and levels of influence in which these grantee communities are taking action. Examples of select strategies and outcomes to date are discussed later and presented in Tables 6 and 7.

In Jamaica Plain, a Boston neighborhood, the youth of the JP Youth Health Equity Collaborative have identified youth employment as a social determinant that disparately shapes the health of youth (and ultimately adults) of color. They have identified that unemployment or underemployment can lead to increased illness, including sexually transmitted infections, malnutrition, stress, depression, increased substance abuse, and lack of or limited access to health care and disability insurance. Their strategies to improve the health of the community are rooted in community organizing and policy change to ensure that there is adequate funding to support youth jobs and that local employers are creating opportunities for the youth of color who live in that community to earn income as well as valuable skills. In 2010, they marched to the Massachusetts State House as a part of a youth

Table 7. Select Examples of Outcomes in Grantee Communities

Outcomes to date: Highlights from communities	
Meeting demand and supporting the farmers' market economy	• SNAP benefits were used a total of 1442 times during the 2009 season to purchase food from Boston farmers' market
	• SNAP and matching Bounty Bucks sales totaled $1310 in 2008, rising considerably to $20 093.77 in 2009.
Increased consumption of fresh fruits and vegetables	• Eighty-seven percent of surveyed SNAP customers reported consuming more fresh produce because of the BBB program.
	• Eighty-four percent of surveyed SNAP customers said that BBB was a very important or important factor in facilitating their purchases of fresh fruits and vegetables.
	• Of the respondents who said Bounty Bucks increased their produce consumption, 87% said they would continue to consume more produce even without the assistance of Bounty Bucks.

Abbreviations: BBB, Boston bounty bucks; SNAP, supplemental nutrition assistance program.

rally for state funding for jobs. They challenge the dominant frame of youth employment as violence prevention and reframe the issue as a civil rights and economic issue. They are strategizing to create a campaign for social norm change, where the connection between racism, social injustice, and health is widely understood and individuals across the community know the steps to make change for health equity.

In the Mason Square neighborhood of Springfield, Massachusetts, data show that rates of food insecurity and hunger are higher than the national average. During the first year of the Center's grant, a resident-led task force completed an assessment of the food environment and found that residents, particularly those without transportation, do not have year-round access to quality and affordable food, making this neighborhood a "food desert." In response, they are developing a plan to extend the seasonal farmer's market to a year-round market and bring a full line grocery store to the neighborhood.

In total, 5 grantees are working on changing the food environment as an approach to address racial inequities in nutrition-related health outcomes. Another set of grantees is working to increase the number of youth of color who enter the health care workforce (eg, nursing, medicine, dentistry, allied health care professions) through the creation of programs for Boston Public School high school students or recent graduates of Boston Public School. Other grantees are also exploring the intersection of education and health and are developing strategies to work with public school leadership and parents to address disparate high school dropout rates. By increasing education and employment opportunities, these grantees are creating pathways out of poverty, increasing earning potential for youth, and building social capital.

These innovative public health strategies reflect a shift in practice for most of these grantee organizations and coalitions who have historically focused on health care, health education, or behavior change. Sustainable policy, system, and environmental approaches do more than attempt to change individual unhealthy behaviors. These approaches aim to give people access to resources that will help them obtain an equal footing and ultimately eliminate social structures that reduce opportunities for people of color.

Evaluating the grant model presents a number of challenges. While changes in related

health outcomes are difficult to capture in 3 years, there is strong evidence that suggests correlations between social factors and health outcomes. This granting model was designed to support institutional, systemic, and policy-level changes that should, in time, result in marked improvements in social conditions that influence community health. The Center has the responsibility of identifying benchmarks for health equity that demonstrate progress toward improved health outcomes.

CONCLUSION

By implementing this multiyear comprehensive grantee model, the Center aims to provide the time, training, and technical assistance required to support grantees through the development and implementation of a policy agenda to promote health equity. For many, a move to address racism and the social determinants of health requires a new understanding of public health and a reassessment of traditional health improvement strategies. It has become clear that a 12-month planning period is imperative to allow communities to collect and assess their data, analyze stakeholders and assets, and develop a plan through which they will address a social determinant of health through systems, policy, or environmental change as a means to addressing a specific health inequity. This first grant year is also a critical time for coalitions and organizations to adjust to new ways of thinking and engaging new partners. This model requires resources to support a multiyear process, including intensive technical assistance from the funding agency.

Central to supporting a granting model such as this is developing a shared definition and understanding of environmental, systems, and policy change as they relate to public health. Grantees are expected to develop long-term visions for how their communities will look (physically, environmentally, and in terms of health outcomes) if they are successful. Having a long-term vision for health equity requires each community to consider how to sustain the work beyond the 3-year grant cycle.

The Center is hopeful that by providing the support to shift community approaches to health promotion, new strategies will emerge that contribute to the evidence base of how social justice can improve public health. In years to come, the Center expects to further develop this model through which a health department supports local efforts to shift public health discourse and practice to include an equity lens. The leadership and staff at the BPHC are committed to, and excited by, further exploration of the role of a local health department in the intersection of public health and social and racial justice.

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